Open Ward Management of Acute Alcoholism

Experience with a Pilot Program

JACK DAVID GORDON, *M.D.*, ROBERT I. LEVY, *M.D.*, and CHARLES B. PERROW, *M.A.*, San Francisco

• **Sixty acutely alcoholic patients were treated in unsegregated rooms of two to twelve beds in a general hospital to determine the feasibility of open ward care. Personnel caring for them were first educated in the nature of alcoholism, the aberrations it produces and treatment with tranquilizing drugs. Fears and objections were overcome.**

Violent or unpredictable patients were excluded from the test, but those with alcoholic hallucinations or delirium suspectible to control were admitted. Preliminary physical examination was done to find out whether there was coincidental disease. In three patients, one with subarachnoid hemorrhage, one with severe anemia and one with pneumonia and shock, this examination followed by prompt treatment was probably life-saving. Tranquilizers, fluids and vitamins were given routinely, by mouth as soon as possible.

Alcoholic patients were found to be no more unmanageable than others.

If it were generally accepted that acutely alcoholic patients, diagnosed as such, could be admitted to open ward care in general hospitals, candor in diagnosis would be encouraged thereby, coincident disease probably would be promptly recognized if present, and long-term treatment for the alcoholic addiction could be begun early.

VERY FEW GENERAL HOSPITALS now admit acutely alcoholic patients routinely without requiring at least segregation in a private room and special nurses. In 1956 the Council on Mental Health of the American Medical Association, in its report to the House of Delegates, strongly urged that tractable alcoholic patients could and, indeed, should be admitted and cared for just as any other ill persons are. Dealing with dangerous degrees of intoxication requires skills that often are not available except in general hospitals. Also coincidental illnesses that could be fatal if not recognized and promptly treated are more likely to be discovered in a general hospital. Despite these and other arguments, however, the question remained: Could acute alcoholism be treated without undue stress on the staff and without disruption of routine?

For the answer, Mount Zion Hospital and Medical Center undertook a pilot program under the sponsorship of the State Alcoholic Rehabilitation Commission of California, now a division of the State Department of Public Health. Selected alcoholic patients were to be admitted to wards or to two-bed or four-bed accommodations, without segregation into special rooms and without special nurses. Half the patients were to be referred from an alcoholic clinic, the Adult Guidance Center, the rest by the attending staff of the hospital. The commission subsidized that part of the costs of hospitalization which the patients were unable to afford. It was felt that 60 patients would be sufficient for adequate demonstration.

One of the authors (Perrow) inquired among the nurses, vocational nurses, aides and student nurses for their reaction to the idea of such a program and the care of the patients. (A study of this inquiry will be reported in detail elsewhere.) More than half approved; they felt that care for acutely alcoholic patients should be carried out in general hospitals. Many mentioned that such patients are indeed ill and need medical care. However, more than two-thirds felt that special facilities would certainly be needed, that their own work would be increased, and that alcoholic patients are more difficult to manage than others. It became clear that these negative attitudes among the persons who were to have the most contact with the patients would hinder if not seriously obstruct the program. Therefore the preliminary practical training and the initial screening of patients were so directed that such attitudes would not be reinforced.

Personnel of all departments that were to participate in the care of alcoholic patients were thoroughly indoctrinated before any such patients were admitted. An internist first presented the physiologic basis of alcohol intoxication, then reviewed the complications due to drinking, both acute and chronic, and carefully delineated and explained the clinical syndromes of hallucinosis and delirium tremens. Training in the treatment with tranquilizing drugs was given in terms of dosage, possible complications and expected effects. Alcoholism was compared with

Presented before the Section on Public Health at the 87th Annual Session of the California Medical Association, Los Angeles, April 27 to 30, 1958.

diabetes mellitus as another chronic condition with acute phases and frequently with long-term complications. A psychiatrist then gave simplified but thorough discussions on the psychodynamics of drinking, drinking patterns, the varieties of personality disorders associated with alcoholism and the meaning of drinking in various emotional conflicts and abnormal interpersonal relationships. At all times the immediate and the long-range values of a non-punitive attitude were stressed. In all cases the alcoholic was to be treated like any other patient with a disease. To the question: "But won't he go right out and drink again?" or "Won't he be back here again sooner or later?" an answer was formulated to show that this project was not meant to be a cure for alcoholism but only a treatment of the acute stage, and perhaps the beginning of a long-range therapy program. Many expressed doubt, as noted above, and many expressed fears. Some were genuinely curious, and asked such questions as, "What do you say to a patient who sees an elephant?"

SELECTION OF PATIENTS

The medical director screened all patients at the start of the program with exceptional care. He excluded—

1. Those with violent delirium tremens;
2. Those whose previous drinking history was unknown to their physicians;
3. Those who were overtly unmanageable, uncooperative and unwilling, showing a degree of disturbance traditionally excluded from general hospital care, regardless of the diagnosis.

He included those with—

1. Alcoholic hallucinosis;
2. Delirium tremens susceptible to easy control;
3. Acute complications of drinking, such as gastritis and intoxication to dangerous levels, or the withdrawal phenomenon commonly known as "the shakes";
4. Compulsive drinkers whose admission would interrupt a current "binge," especially in the early phase.

In addition the first few patients were selected to provide a variety of personality types and various professions to suggest the complexity and multiple, individual factors in the make-up of an alcoholic patient.

THE ADMISSION PROCEDURE

Every patient was first seen by the Adult Guidance Center therapist or by his private physician, so that his general condition was known before his coming to the hospital. The medical director made a preliminary screening by telephone and, when indicated, saw the patient before admission. Every patient was accompanied by an attendant, a friend or a relative. The patient first came to the emergency room where he was promptly seen by the medical resident on call, who made a preliminary physical examination with special attention to blood pressure, heart and lungs and abdominal viscera. The purpose was to rule out coincident disease, such as pneumonia, or any abnormalities which might contraindicate use of certain drugs or strong sedatives. The first sedation was administered in the emergency room and when the effect was apparent, usually within 30 minutes, the orders for care were written and the patient was wheeled to his assigned bed in the hospital. His care then did not differ from that of any other patient. He was placed in an accommodation of two to 12 beds—but not in a private room. At the beginning of the program every step was carefully supervised by the medical director.

THE MEDICAL MANAGEMENT

The initial treatment in the emergency room consisted of intramuscular or intravenous injection of 50 to 100 mg. of promazine, the amount depending on the need for sedation. The same drug was administered in 50- to 100-mg. doses intramuscularly every two to four hours as required for restlessness. Meprobamate orally, 400 to 800 mg. every six hours, was begun as soon as possible. Attention to hydration consisted in intravenous fluid therapy when indicated and oral administration as soon as possible. A multiple-vitamin supplement was given in the intravenous fluids or by intramuscular injection, or orally when tolerated. Proclorperazine was sometimes administered by intramuscular injection and orally. Some patients required no sedation whatever, being too ill from accompanying disease. Narcotic drugs or liquid medications recognizable by odor or taste were not routinely given.

A complete medical work-up was performed on all patients, including history-taking, physical examination and liver function tests, as well as routine laboratory studies. Other laboratory studies were ordered as indicated.

THE STUDY TEAM

Most of the patients were seen by a social worker who elicited environmental information and arranged appointments for follow-up care. A resident in the psychiatry department assigned to the program made a diagnostic work-up. The staff concerned met weekly to keep current problems in focus. The social workers, medical director, psychiatric consultant, psychiatry resident, chief nurse, a soci-

ologist and representatives from the admitting department, emergency room and the hospital administration attended meetings when special problems arose involving those departments. A recommendation for follow-up care was given to the referring physician or to the Adult Guidance Center.

CHARACTERISTICS OF PATIENTS

Among the first 51 patients, ages ranged from 27 to 61 years, average 48 years. Eighteen were women. The average number of years of drinking was 19, with a range from 2 to 40 years. There was no significant difference between the clinic patients and the private patients in these respects.

From questionnaires that were completed by 33 patients it was learned that 11 of them had been treated for a similar condition in three or more of the following ways: By a private physician, in a private sanatorium, in a county hospital and in a state hospital. Sixteen had had at least one admission to the county hospital. Since admission to the county hospital for alcohol intoxication indicates an extreme degree of illness, the range of patients in the study was probably of average clinical severity. The average hospital stay was four and one-half days. Among the first 44 patients, 16 had suggestive or overt evidence of liver disease. Fourteen had coincidental disease of a serious nature, such as paroxysmal tachycardia, diabetes mellitus, pneumonia, subarachnoid hemorrhage, severe anemia and epilepsy. For three of these patients, the recognition and prompt treatment of the accompanying disease was felt to have been life saving. In these cases the accompanying disease was subarachnoid hemorrhage, anemia (less than 5 gm. of hemoglobin per 100 cc.), and pneumonia with shock.

MANAGEMENT PROBLEMS

In two of the first 60 patients, management problems were so great that transfer to the county psychiatric division had to be arranged. One of them had Korsakoff psychosis, pellagra and lice—a true "Skid Row" complex. The second had severe paranoid ideas, a convulsion, cirrhosis and pellagra. These patients might have been managed in segregated rooms with special attendance, but it was felt that the chronic nature of the conditions outweighed the acute. Two other patients had to be restrained for brief periods soon after admittance. Six were recorded as mildly difficult—wandering in the hall, disturbing a roommate, asking to sign out, complaining about the drugs being given and refusing to take them, and one patient breaking a toilet fixture but promptly becoming quiet and manageable thereafter.

For comparison, a review of the records of 200 patients admitted for "cirrhosis," "gastritis," and "gastroenteritis" in 1956 was carried out, and it appeared that at least 31 were overtly intoxicated. For seven, segregation, special nurses, restraints or similar measures were needed. Another six were described as uncooperative or noisy. Thus, 43 per cent of these presented the kind of problems encountered in only 10 per cent of the patients in the present study.

THE IMPACT OF THE PROGRAM ON THE HOSPITAL

After ward treatment of 60 cases, the medical board approved continuance of the program. The attitudes of many of the nursing staff showed a definite reversal from the preliminary questionnaire, although some were still definitely negative. Most of the nurses who participated came to feel that it is much better for their purpose to have alcoholic patients admitted under the proper diagnosis, rather than a false one, and most (80 per cent) feel the hospital should now make it a policy to admit alcoholic patients without the traditional requirements of special rooms and special nurses, providing there is adequate screening of patients.

CONCLUSIONS

Our experiences show that with careful selection of patients, preliminary training and indoctrination of personnel, and the use of modern tranquilizing drugs, most patients with acute illness due to drinking may be successfully managed in a general hospital without segregation or special care.

From the patient's standpoint, such care is an ideal treatment of his symptoms, provides a break in a compulsive drinking spell and, at times, may be life-saving through the timely recognition and treatment of coincidental illness.

Ward care provides an ideal setting for the initiation of long-term treatment of alcoholism.

2320 Sutter Street, San Francisco 15 (Gordon).